

**Introduced by Senator Hernandez**

February 6, 2014

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An act to amend Sections 1357.503 and 1399.849 of the Health and Safety Code, and to amend Sections 10753.05 and 10965.3 of the Insurance Code, relating to health care coverage.

**LEGISLATIVE COUNSEL'S DIGEST**

SB 959, as introduced, Hernandez. Health care coverage: small group and individual markets: single risk pool: index rate.

Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms that take effect January 1, 2014. Among other things, PPACA requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers. PPACA requires a health insurance issuer to consider all enrollees in its individual market plans to be part of a single risk pool and to consider all enrollees in its small group market plans to be part of a single risk pool. PPACA also requires an issuer to establish an index rate for each of those markets based on the total combined claim costs for providing essential health benefits within the single risk pool for that market and authorizes the issuer to vary premium rates from the index rate based only on specified factors. PPACA requires that the index rate be adjusted based on Exchange user fees and expected payments and charges under certain risk adjustment and reinsurance programs.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation

of health insurers by the Department of Insurance. Existing law requires a health care service plan and a health insurer to consider as a single risk pool the claims experience of all enrollees and insureds in its nongrandfathered small employer plans, and to also consider as a single risk pool the claims experience of all enrollees and insureds in its nongrandfathered individual market plans. Existing law requires a plan or insurer to establish an index rate for those markets, as specified, and authorizes the plan or insurer to vary premium rates from the index rate based only on specified factors. Existing law requires that the index rate be adjusted based on expected payments and charges under the risk adjustment and reinsurance programs specified under PPACA.

This bill would require that the index rate also be adjusted based on Exchange user fees, as specified under PPACA. Because a willful violation of this requirement by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: yes.

*The people of the State of California do enact as follows:*

1     SECTION 1. Section 1357.503 of the Health and Safety Code  
2     is amended to read:  
3     1357.503. (a) (1) On and after October 1, 2013, a plan shall  
4     fairly and affirmatively offer, market, and sell all of the plan's  
5     small employer health care service plan contracts for plan years  
6     on or after January 1, 2014, to all small employers in each service  
7     area in which the plan provides or arranges for the provision of  
8     health care services.  
9     (2) On and after October 1, 2013, a plan shall make available  
10    to each small employer all small employer health care service plan  
11    contracts that the plan offers and sells to small employers or to  
12    associations that include small employers in this state for plan  
13    years on or after January 1, 2014. Health coverage through an  
14    association that is not related to employment shall be considered

1 individual coverage pursuant to Section 144.102(c) of Title 45 of  
2 the Code of Federal Regulations.

3 (3) A plan that offers qualified health plans through the  
4 Exchange shall be deemed to be in compliance with paragraphs  
5 (1) and (2) with respect to small employer health care service plan  
6 contracts offered through the Exchange in those geographic regions  
7 in which the plan offers plan contracts through the Exchange.

8 (b) A plan shall provide enrollment periods consistent with  
9 PPACA and described in Section 155.725 of Title 45 of the Code  
10 of Federal Regulations. Commencing January 1, 2014, a plan shall  
11 provide special enrollment periods consistent with the special  
12 enrollment periods described in Section 1399.849, to the extent  
13 permitted by PPACA, except for the triggering events identified  
14 in paragraphs (d)(3) and (d)(6) of Section 155.420 of Title 45 of  
15 the Code of Federal Regulations with respect to plan contracts  
16 offered through the Exchange.

17 (c) No plan or solicitor shall induce or otherwise encourage a  
18 small employer to separate or otherwise exclude an eligible  
19 employee from a health care service plan contract that is provided  
20 in connection with employee's employment or membership in a  
21 guaranteed association.

22 (d) Every plan shall file with the director the reasonable  
23 employee participation requirements and employer contribution  
24 requirements that will be applied in offering its plan contracts.  
25 Participation requirements shall be applied uniformly among all  
26 small employer groups, except that a plan may vary application  
27 of minimum employee participation requirements by the size of  
28 the small employer group and whether the employer contributes  
29 100 percent of the eligible employee's premium. Employer  
30 contribution requirements shall not vary by employer size. A health  
31 care service plan shall not establish a participation requirement  
32 that (1) requires a person who meets the definition of a dependent  
33 in Section 1357.500 to enroll as a dependent if he or she is  
34 otherwise eligible for coverage and wishes to enroll as an eligible  
35 employee and (2) allows a plan to reject an otherwise eligible small  
36 employer because of the number of persons that waive coverage  
37 due to coverage through another employer. Members of an  
38 association eligible for health coverage under subdivision (m) of  
39 Section 1357.500, but not electing any health coverage through  
40 the association, shall not be counted as eligible employees for

1 purposes of determining whether the guaranteed association meets  
2 a plan's reasonable participation standards.

3 (e) The plan shall not reject an application from a small  
4 employer for a small employer health care service plan contract  
5 if all of the following conditions are met:

6 (1) The small employer offers health benefits to 100 percent of  
7 its eligible employees. Employees who waive coverage on the  
8 grounds that they have other group coverage shall not be counted  
9 as eligible employees.

10 (2) The small employer agrees to make the required premium  
11 payments.

12 (3) The small employer agrees to inform the small employer's  
13 employees of the availability of coverage and the provision that  
14 those not electing coverage must wait until the next open  
15 enrollment or a special enrollment period to obtain coverage  
16 through the group if they later decide they would like to have  
17 coverage.

18 (4) The employees and their dependents who are to be covered  
19 by the plan contract work or reside in the service area in which  
20 the plan provides or otherwise arranges for the provision of health  
21 care services.

22 (f) No plan or solicitor shall, directly or indirectly, engage in  
23 the following activities:

24 (1) Encourage or direct small employers to refrain from filing  
25 an application for coverage with a plan because of the health status,  
26 claims experience, industry, occupation of the small employer, or  
27 geographic location provided that it is within the plan's approved  
28 service area.

29 (2) Encourage or direct small employers to seek coverage from  
30 another plan because of the health status, claims experience,  
31 industry, occupation of the small employer, or geographic location  
32 provided that it is within the plan's approved service area.

33 (3) Employ marketing practices or benefit designs that will have  
34 the effect of discouraging the enrollment of individuals with  
35 significant health needs or discriminate based on an individual's  
36 race, color, national origin, present or predicted disability, age,  
37 sex, gender identity, sexual orientation, expected length of life,  
38 degree of medical dependency, quality of life, or other health  
39 conditions.

(g) A plan shall not, directly or indirectly, enter into any contract, agreement, or arrangement with a solicitor that provides for or results in the compensation paid to a solicitor for the sale of a health care service plan contract to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer. This subdivision does not apply to a compensation arrangement that provides compensation to a solicitor on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

(h) (1) A policy or contract that covers a small employer, as defined in Section 1304(b) of PPACA and in Section 1357.500, shall not establish rules for eligibility, including continued eligibility, of an individual, or dependent of an individual, to enroll under the terms of the policy or contract based on any of the following health status-related factors:

- (A) Health status.
- (B) Medical condition, including physical and mental illnesses.
- (C) Claims experience.
- (D) Receipt of health care.
- (E) Medical history.
- (F) Genetic information.
- (G) Evidence of insurability, including conditions arising out of acts of domestic violence.
- (H) Disability.
- (I) Any other health status-related factor as determined by any federal regulations, rules, or guidance issued pursuant to Section 2705 of the federal Public Health Service Act.

(2) Notwithstanding Section 1389.1, a health care service plan shall not require an eligible employee or dependent to fill out a health assessment or medical questionnaire prior to enrollment under a small employer health care service plan contract. A health care service plan shall not acquire or request information that relates to a health status-related factor from the applicant or his or her dependent or any other source prior to enrollment of the individual.

(i) (1) A health care service plan shall consider as a single risk pool for rating purposes in the small employer market the claims experience of all enrollees in all nongrandfathered small employer

1 health benefit plans offered by the health care service plan in this  
2 state, whether offered as health care service plan contracts or health  
3 insurance policies, including those insureds and enrollees who  
4 enroll in coverage through the Exchange and insureds and enrollees  
5 covered by the health care service plan outside of the Exchange.

6 (2) At least each calendar year, and no more frequently than  
7 each calendar quarter, a health care service plan shall establish an  
8 index rate for the small employer market in the state based on the  
9 total combined claims costs for providing essential health benefits,  
10 as defined pursuant to Section 1302 of PPACA and Section  
11 1367.005, within the single risk pool required under paragraph  
12 (1). The index rate shall be adjusted on a marketwide basis based  
13 on the total expected marketwide payments and charges under the  
14 risk adjustment and reinsurance programs established for the state  
15 pursuant to Sections 1343 and 1341 of PPACA *and Exchange user*  
16 *fees, as described in subdivision (d) of Section 156.80 of Title 45*  
17 *of the Code of Federal Regulations*. The premium rate for all of  
18 the health care service plan's nongrandfathered small employer  
19 health care service plan contracts shall use the applicable index  
20 rate, as adjusted for total expected marketwide payments and  
21 charges under the risk adjustment and reinsurance programs  
22 established for the state pursuant to Sections 1343 and 1341 of  
23 PPACA, subject only to the adjustments permitted under paragraph  
24 (3).

25 (3) A health care service plan may vary premium rates for a  
26 particular nongrandfathered small employer health care service  
27 plan contract from its index rate based only on the following  
28 actuarially justified plan-specific factors:

29 (A) The actuarial value and cost-sharing design of the plan  
30 contract.

31 (B) The plan contract's provider network, delivery system  
32 characteristics, and utilization management practices.

33 (C) The benefits provided under the plan contract that are in  
34 addition to the essential health benefits, as defined pursuant to  
35 Section 1302 of PPACA. These additional benefits shall be pooled  
36 with similar benefits within the single risk pool required under  
37 paragraph (1) and the claims experience from those benefits shall  
38 be utilized to determine rate variations for plan contracts that offer  
39 those benefits in addition to essential health benefits.

1 (D) With respect to catastrophic plans, as described in subsection  
2 (e) of Section 1302 of PPACA, the expected impact of the specific  
3 eligibility categories for those plans.

4 (E) Administrative costs, excluding any user fees required by  
5 the Exchange.

6 (j) A plan shall comply with the requirements of Section 1374.3.

7 (k) (1) Except as provided in paragraph (2), if Section 2702 of  
8 the federal Public Health Service Act (42 U.S.C. Sec. 300gg-1),  
9 as added by Section 1201 of PPACA, is repealed, this section shall  
10 become inoperative 12 months after the repeal date, in which case  
11 health care service plans subject to this section shall instead be  
12 governed by Section 1357.03 to the extent permitted by federal  
13 law, and all references in this article to this section shall instead  
14 refer to Section 1357.03 except for purposes of paragraph (2).

15 (2) Subdivision (b) shall remain operative with respect to health  
16 care service plan contracts offered through the Exchange.

17 SEC. 2. Section 1399.849 of the Health and Safety Code is  
18 amended to read:

19 1399.849. (a) (1) On and after October 1, 2013, a plan shall  
20 fairly and affirmatively offer, market, and sell all of the plan's  
21 health benefit plans that are sold in the individual market for policy  
22 years on or after January 1, 2014, to all individuals and dependents  
23 in each service area in which the plan provides or arranges for the  
24 provision of health care services. A plan shall limit enrollment in  
25 individual health benefit plans to open enrollment periods and  
26 special enrollment periods as provided in subdivisions (c) and (d).

27 (2) A plan shall allow the subscriber of an individual health  
28 benefit plan to add a dependent to the subscriber's plan at the  
29 option of the subscriber, consistent with the open enrollment,  
30 annual enrollment, and special enrollment period requirements in  
31 this section.

32 (b) An individual health benefit plan issued, amended, or  
33 renewed on or after January 1, 2014, shall not impose any  
34 preexisting condition provision upon any individual.

35 (c) (1) A plan shall provide an initial open enrollment period  
36 from October 1, 2013, to March 31, 2014, inclusive, and annual  
37 enrollment periods for plan years on or after January 1, 2015, from  
38 October 15 to December 7, inclusive, of the preceding calendar  
39 year.

(2) Pursuant to Section 147.104(b)(2) of Title 45 of the Code of Federal Regulations, for individuals enrolled in noncalendar year individual health plan contracts, a plan shall provide a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014.

(d) (1) Subject to paragraph (2), commencing January 1, 2014, a plan shall allow an individual to enroll in or change individual health benefit plans as a result of the following triggering events:

(A) He or she or his or her dependent loses minimum essential coverage. For purposes of this paragraph, the following definitions shall apply:

(i) “Minimum essential coverage” has the same meaning as that term is defined in subsection (f) of Section 5000A of the Internal Revenue Code (26 U.S.C. Sec. 5000A).

(ii) “Loss of minimum essential coverage” includes, but is not limited to, loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations and the circumstances described in Section 1163 of Title 29 of the United States Code. “Loss of minimum essential coverage” also includes loss of that coverage for a reason that is not due to the fault of the individual.

(iii) “Loss of minimum essential coverage” does not include loss of that coverage due to the individual’s failure to pay premiums on a timely basis or situations allowing for a rescission, subject to clause (ii) and Sections 1389.7 and 1389.21.

(B) He or she gains a dependent or becomes a dependent.

(C) He or she is mandated to be covered as a dependent pursuant to a valid state or federal court order.

(D) He or she has been released from incarceration.

(E) His or her health coverage issuer substantially violated a material provision of the health coverage contract.

(F) He or she gains access to new health benefit plans as a result of a permanent move.

(G) He or she was receiving services from a contracting provider under another health benefit plan, as defined in Section 1399.845 or Section 10965 of the Insurance Code, for one of the conditions described in subdivision (c) of Section 1373.96 and that provider is no longer participating in the health benefit plan.

(H) He or she demonstrates to the Exchange, with respect to health benefit plans offered through the Exchange, or to the

1 department, with respect to health benefit plans offered outside  
2 the Exchange, that he or she did not enroll in a health benefit plan  
3 during the immediately preceding enrollment period available to  
4 the individual because he or she was misinformed that he or she  
5 was covered under minimum essential coverage.

6 (I) He or she is a member of the reserve forces of the United  
7 States military returning from active duty or a member of the  
8 California National Guard returning from active duty service under  
9 Title 32 of the United States Code.

10 (J) With respect to individual health benefit plans offered  
11 through the Exchange, in addition to the triggering events listed  
12 in this paragraph, any other events listed in Section 155.420(d) of  
13 Title 45 of the Code of Federal Regulations.

14 (2) With respect to individual health benefit plans offered  
15 outside the Exchange, an individual shall have 60 days from the  
16 date of a triggering event identified in paragraph (1) to apply for  
17 coverage from a health care service plan subject to this section.  
18 With respect to individual health benefit plans offered through the  
19 Exchange, an individual shall have 60 days from the date of a  
20 triggering event identified in paragraph (1) to select a plan offered  
21 through the Exchange, unless a longer period is provided in Part  
22 155 (commencing with Section 155.10) of Subchapter B of Subtitle  
23 A of Title 45 of the Code of Federal Regulations.

24 (e) With respect to individual health benefit plans offered  
25 through the Exchange, the effective date of coverage required  
26 pursuant to this section shall be consistent with the dates specified  
27 in Section 155.410 or 155.420 of Title 45 of the Code of Federal  
28 Regulations, as applicable. A dependent who is a registered  
29 domestic partner pursuant to Section 297 of the Family Code shall  
30 have the same effective date of coverage as a spouse.

31 (f) With respect to individual health benefit plans offered outside  
32 the Exchange, the following provisions shall apply:

33 (1) After an individual submits a completed application form  
34 for a plan contract, the health care service plan shall, within 30  
35 days, notify the individual of the individual's actual premium  
36 charges for that plan established in accordance with Section  
37 1399.855. The individual shall have 30 days in which to exercise  
38 the right to buy coverage at the quoted premium charges.

39 (2) With respect to an individual health benefit plan for which  
40 an individual applies during the initial open enrollment period

1 described in subdivision (c), when the subscriber submits a  
2 premium payment, based on the quoted premium charges, and that  
3 payment is delivered or postmarked, whichever occurs earlier, by  
4 December 15, 2013, coverage under the individual health benefit  
5 plan shall become effective no later than January 1, 2014. When  
6 that payment is delivered or postmarked within the first 15 days  
7 of any subsequent month, coverage shall become effective no later  
8 than the first day of the following month. When that payment is  
9 delivered or postmarked between December 16, 2013, and  
10 December 31, 2013, inclusive, or after the 15th day of any  
11 subsequent month, coverage shall become effective no later than  
12 the first day of the second month following delivery or postmark  
13 of the payment.

14 (3) With respect to an individual health benefit plan for which  
15 an individual applies during the annual open enrollment period  
16 described in subdivision (c), when the individual submits a  
17 premium payment, based on the quoted premium charges, and that  
18 payment is delivered or postmarked, whichever occurs later, by  
19 December 15, coverage shall become effective as of the following  
20 January 1. When that payment is delivered or postmarked within  
21 the first 15 days of any subsequent month, coverage shall become  
22 effective no later than the first day of the following month. When  
23 that payment is delivered or postmarked between December 16  
24 and December 31, inclusive, or after the 15th day of any subsequent  
25 month, coverage shall become effective no later than the first day  
26 of the second month following delivery or postmark of the  
27 payment.

28 (4) With respect to an individual health benefit plan for which  
29 an individual applies during a special enrollment period described  
30 in subdivision (d), the following provisions shall apply:

31 (A) When the individual submits a premium payment, based  
32 on the quoted premium charges, and that payment is delivered or  
33 postmarked, whichever occurs earlier, within the first 15 days of  
34 the month, coverage under the plan shall become effective no later  
35 than the first day of the following month. When the premium  
36 payment is neither delivered nor postmarked until after the 15th  
37 day of the month, coverage shall become effective no later than  
38 the first day of the second month following delivery or postmark  
39 of the payment.

1 (B) Notwithstanding subparagraph (A), in the case of a birth,  
2 adoption, or placement for adoption, the coverage shall be effective  
3 on the date of birth, adoption, or placement for adoption.

4 (C) Notwithstanding subparagraph (A), in the case of marriage  
5 or becoming a registered domestic partner or in the case where a  
6 qualified individual loses minimum essential coverage, the  
7 coverage effective date shall be the first day of the month following  
8 the date the plan receives the request for special enrollment.

9 (g) (1) A health care service plan shall not establish rules for  
10 eligibility, including continued eligibility, of any individual to  
11 enroll under the terms of an individual health benefit plan based  
12 on any of the following factors:

13 (A) Health status.

14 (B) Medical condition, including physical and mental illnesses.

15 (C) Claims experience.

16 (D) Receipt of health care.

17 (E) Medical history.

18 (F) Genetic information.

19 (G) Evidence of insurability, including conditions arising out  
20 of acts of domestic violence.

21 (H) Disability.

22 (I) Any other health status-related factor as determined by any  
23 federal regulations, rules, or guidance issued pursuant to Section  
24 2705 of the federal Public Health Service Act.

25 (2) Notwithstanding Section 1389.1, a health care service plan  
26 shall not require an individual applicant or his or her dependent  
27 to fill out a health assessment or medical questionnaire prior to  
28 enrollment under an individual health benefit plan. A health care  
29 service plan shall not acquire or request information that relates  
30 to a health status-related factor from the applicant or his or her  
31 dependent or any other source prior to enrollment of the individual.

32 (h) (1) A health care service plan shall consider as a single risk  
33 pool for rating purposes in the individual market the claims  
34 experience of all insureds and enrollees in all nongrandfathered  
35 individual health benefit plans offered by that health care service  
36 plan in this state, whether offered as health care service plan  
37 contracts or individual health insurance policies, including those  
38 insureds and enrollees who enroll in individual coverage through  
39 the Exchange and insureds and enrollees who enroll in individual  
40 coverage outside of the Exchange. Student health insurance

1 coverage, as that coverage is defined in Section 147.145(a) of Title  
2 45 of the Code of Federal Regulations, shall not be included in a  
3 health care service plan's single risk pool for individual coverage.

4 (2) Each calendar year, a health care service plan shall establish  
5 an index rate for the individual market in the state based on the  
6 total combined claims costs for providing essential health benefits,  
7 as defined pursuant to Section 1302 of PPACA, within the single  
8 risk pool required under paragraph (1). The index rate shall be  
9 adjusted on a marketwide basis based on the total expected  
10 marketwide payments and charges under the risk adjustment and  
11 reinsurance programs established for the state pursuant to Sections  
12 1343 and 1341 of PPACA *and Exchange user fees, as described*  
13 *in subdivision (d) of Section 156.80 of Title 45 of the Code of*  
14 *Federal Regulations*. The premium rate for all of the health care  
15 service plan's health benefit plans in the individual market shall  
16 use the applicable index rate, as adjusted for total expected  
17 marketwide payments and charges under the risk adjustment and  
18 reinsurance programs established for the state pursuant to Sections  
19 1343 and 1341 of PPACA, subject only to the adjustments  
20 permitted under paragraph (3).

21 (3) A health care service plan may vary premium rates for a  
22 particular health benefit plan from its index rate based only on the  
23 following actuarially justified plan-specific factors:

24 (A) The actuarial value and cost-sharing design of the health  
25 benefit plan.

26 (B) The health benefit plan's provider network, delivery system  
27 characteristics, and utilization management practices.

28 (C) The benefits provided under the health benefit plan that are  
29 in addition to the essential health benefits, as defined pursuant to  
30 Section 1302 of PPACA and Section 1367.005. These additional  
31 benefits shall be pooled with similar benefits within the single risk  
32 pool required under paragraph (1) and the claims experience from  
33 those benefits shall be utilized to determine rate variations for  
34 plans that offer those benefits in addition to essential health  
35 benefits.

36 (D) With respect to catastrophic plans, as described in subsection  
37 (e) of Section 1302 of PPACA, the expected impact of the specific  
38 eligibility categories for those plans.

39 (E) Administrative costs, excluding user fees required by the  
40 Exchange.

1 (i) This section shall only apply with respect to individual health  
2 benefit plans for policy years on or after January 1, 2014.

3 (j) This section shall not apply to an individual health benefit  
4 plan that is a grandfathered health plan.

5 (k) If Section 5000A of the Internal Revenue Code, as added  
6 by Section 1501 of PPACA, is repealed or amended to no longer  
7 apply to the individual market, as defined in Section 2791 of the  
8 federal Public Health Service Act (42 U.S.C. Sec. 300gg-4),  
9 subdivisions (a), (b), and (g) shall become inoperative 12 months  
10 after that repeal or amendment.

11 SEC. 3. Section 10753.05 of the Insurance Code is amended  
12 to read:

13 10753.05. (a) No group or individual policy or contract or  
14 certificate of group insurance or statement of group coverage  
15 providing benefits to employees of small employers as defined in  
16 this chapter shall be issued or delivered by a carrier subject to the  
17 jurisdiction of the commissioner regardless of the situs of the  
18 contract or master policyholder or of the domicile of the carrier  
19 nor, except as otherwise provided in Sections 10270.91 and  
20 10270.92, shall a carrier provide coverage subject to this chapter  
21 until a copy of the form of the policy, contract, certificate, or  
22 statement of coverage is filed with and approved by the  
23 commissioner in accordance with Sections 10290 and 10291, and  
24 the carrier has complied with the requirements of Section 10753.17.

25 (b) (1) On and after October 1, 2013, each carrier shall fairly  
26 and affirmatively offer, market, and sell all of the carrier's health  
27 benefit plans that are sold to, offered through, or sponsored by,  
28 small employers or associations that include small employers for  
29 plan years on or after January 1, 2014, to all small employers in  
30 each geographic region in which the carrier makes coverage  
31 available or provides benefits.

32 (2) A carrier that offers qualified health plans through the  
33 Exchange shall be deemed to be in compliance with paragraph (1)  
34 with respect to health benefit plans offered through the Exchange  
35 in those geographic regions in which the carrier offers plans  
36 through the Exchange.

37 (3) A carrier shall provide enrollment periods consistent with  
38 PPACA and described in Section 155.725 of Title 45 of the Code  
39 of Federal Regulations. Commencing January 1, 2014, a carrier  
40 shall provide special enrollment periods consistent with the special

1 enrollment periods described in Section 10965.3, to the extent  
2 permitted by PPACA, except for the triggering events identified  
3 in paragraphs (d)(3) and (d)(6) of Section 155.420 of Title 45 of  
4 the Code of Federal Regulations with respect to health benefit  
5 plans offered through the Exchange.

6 (4) Nothing in this section shall be construed to require an  
7 association, or a trust established and maintained by an association  
8 to receive a master insurance policy issued by an admitted insurer  
9 and to administer the benefits thereof solely for association  
10 members, to offer, market or sell a benefit plan design to those  
11 who are not members of the association. However, if the  
12 association markets, offers or sells a benefit plan design to those  
13 who are not members of the association it is subject to the  
14 requirements of this section. This shall apply to an association that  
15 otherwise meets the requirements of paragraph (8) formed by  
16 merger of two or more associations after January 1, 1992, if the  
17 predecessor organizations had been in active existence on January  
18 1, 1992, and for at least five years prior to that date and met the  
19 requirements of paragraph (5).

20 (5) A carrier which (A) effective January 1, 1992, and at least  
21 20 years prior to that date, markets, offers, or sells benefit plan  
22 designs only to all members of one association and (B) does not  
23 market, offer or sell any other individual, selected group, or group  
24 policy or contract providing medical, hospital and surgical benefits  
25 shall not be required to market, offer, or sell to those who are not  
26 members of the association. However, if the carrier markets, offers  
27 or sells any benefit plan design or any other individual, selected  
28 group, or group policy or contract providing medical, hospital and  
29 surgical benefits to those who are not members of the association  
30 it is subject to the requirements of this section.

31 (6) Each carrier that sells health benefit plans to members of  
32 one association pursuant to paragraph (5) shall submit an annual  
33 statement to the commissioner which states that the carrier is selling  
34 health benefit plans pursuant to paragraph (5) and which, for the  
35 one association, lists all the information required by paragraph (7).

36 (7) Each carrier that sells health benefit plans to members of  
37 any association shall submit an annual statement to the  
38 commissioner which lists each association to which the carrier  
39 sells health benefit plans, the industry or profession which is served  
40 by the association, the association's membership criteria, a list of

1 officers, the state in which the association is organized, and the  
2 site of its principal office.

3 (8) For purposes of paragraphs (4) and (6), an association is a  
4 nonprofit organization comprised of a group of individuals or  
5 employers who associate based solely on participation in a  
6 specified profession or industry, accepting for membership any  
7 individual or small employer meeting its membership criteria,  
8 which do not condition membership directly or indirectly on the  
9 health or claims history of any person, which uses membership  
10 dues solely for and in consideration of the membership and  
11 membership benefits, except that the amount of the dues shall not  
12 depend on whether the member applies for or purchases insurance  
13 offered by the association, which is organized and maintained in  
14 good faith for purposes unrelated to insurance, which has been in  
15 active existence on January 1, 1992, and at least five years prior  
16 to that date, which has a constitution and bylaws, or other  
17 analogous governing documents which provide for election of the  
18 governing board of the association by its members, which has  
19 contracted with one or more carriers to offer one or more health  
20 benefit plans to all individual members and small employer  
21 members in this state. Health coverage through an association that  
22 is not related to employment shall be considered individual  
23 coverage pursuant to Section 144.102(c) of Title 45 of the Code  
24 of Federal Regulations.

25 (c) On and after October 1, 2013, each carrier shall make  
26 available to each small employer all health benefit plans that the  
27 carrier offers or sells to small employers or to associations that  
28 include small employers for plan years on or after January 1, 2014.  
29 Notwithstanding subdivision (d) of Section 10753, for purposes  
30 of this subdivision, companies that are affiliated companies or that  
31 are eligible to file a consolidated income tax return shall be treated  
32 as one carrier.

33 (d) Each carrier shall do all of the following:

34 (1) Prepare a brochure that summarizes all of its health benefit  
35 plans and make this summary available to small employers, agents,  
36 and brokers upon request. The summary shall include for each  
37 plan information on benefits provided, a generic description of the  
38 manner in which services are provided, such as how access to  
39 providers is limited, benefit limitations, required copayments and  
40 deductibles, an explanation of how creditable coverage is calculated

1 if a waiting period is imposed, and a telephone number that can  
2 be called for more detailed benefit information. Carriers are  
3 required to keep the information contained in the brochure accurate  
4 and up to date, and, upon updating the brochure, send copies to  
5 agents and brokers representing the carrier. Any entity that provides  
6 administrative services only with regard to a health benefit plan  
7 written or issued by another carrier shall not be required to prepare  
8 a summary brochure which includes that benefit plan.

9 (2) For each health benefit plan, prepare a more detailed  
10 evidence of coverage and make it available to small employers,  
11 agents and brokers upon request. The evidence of coverage shall  
12 contain all information that a prudent buyer would need to be aware  
13 of in making selections of benefit plan designs. An entity that  
14 provides administrative services only with regard to a health benefit  
15 plan written or issued by another carrier shall not be required to  
16 prepare an evidence of coverage for that health benefit plan.

17 (3) Provide copies of the current summary brochure to all agents  
18 or brokers who represent the carrier and, upon updating the  
19 brochure, send copies of the updated brochure to agents and brokers  
20 representing the carrier for the purpose of selling health benefit  
21 plans.

22 (4) Notwithstanding subdivision (c) of Section 10753, for  
23 purposes of this subdivision, companies that are affiliated  
24 companies or that are eligible to file a consolidated income tax  
25 return shall be treated as one carrier.

26 (e) Every agent or broker representing one or more carriers for  
27 the purpose of selling health benefit plans to small employers shall  
28 do all of the following:

29 (1) When providing information on a health benefit plan to a  
30 small employer but making no specific recommendations on  
31 particular benefit plan designs:

32 (A) Advise the small employer of the carrier's obligation to sell  
33 to any small employer any of the health benefit plans it offers to  
34 small employers, consistent with PPACA, and provide them, upon  
35 request, with the actual rates that would be charged to that  
36 employer for a given health benefit plan.

37 (B) Notify the small employer that the agent or broker will  
38 procure rate and benefit information for the small employer on  
39 any health benefit plan offered by a carrier for whom the agent or  
40 broker sells health benefit plans.

1 (C) Notify the small employer that, upon request, the agent or  
2 broker will provide the small employer with the summary brochure  
3 required in paragraph (1) of subdivision (d) for any benefit plan  
4 design offered by a carrier whom the agent or broker represents.

5 (D) Notify the small employer of the availability of coverage  
6 and the availability of tax credits for certain employers consistent  
7 with PPACA and state law, including any rules, regulations, or  
8 guidance issued in connection therewith.

9 (2) When recommending a particular benefit plan design or  
10 designs, advise the small employer that, upon request, the agent  
11 will provide the small employer with the brochure required by  
12 paragraph (1) of subdivision (d) containing the benefit plan design  
13 or designs being recommended by the agent or broker.

14 (3) Prior to filing an application for a small employer for a  
15 particular health benefit plan:

16 (A) For each of the health benefit plans offered by the carrier  
17 whose health benefit plan the agent or broker is presenting, provide  
18 the small employer with the benefit summary required in paragraph  
19 (1) of subdivision (d) and the premium for that particular employer.

20 (B) Notify the small employer that, upon request, the agent or  
21 broker will provide the small employer with an evidence of  
22 coverage brochure for each health benefit plan the carrier offers.

23 (C) Obtain a signed statement from the small employer  
24 acknowledging that the small employer has received the disclosures  
25 required by this paragraph and Section 10753.16.

26 (f) No carrier, agent, or broker shall induce or otherwise  
27 encourage a small employer to separate or otherwise exclude an  
28 eligible employee from a health benefit plan which, in the case of  
29 an eligible employee meeting the definition in paragraph (1) of  
30 subdivision (f) of Section 10753, is provided in connection with  
31 the employee's employment or which, in the case of an eligible  
32 employee as defined in paragraph (2) of subdivision (f) of Section  
33 10753, is provided in connection with a guaranteed association.

34 (g) No carrier shall reject an application from a small employer  
35 for a health benefit plan provided:

36 (1) The small employer as defined by subparagraph (A) of  
37 paragraph (1) of subdivision (q) of Section 10753 offers health  
38 benefits to 100 percent of its eligible employees as defined in  
39 paragraph (1) of subdivision (f) of Section 10753. Employees who

1 waive coverage on the grounds that they have other group coverage  
2 shall not be counted as eligible employees.

3 (2) The small employer agrees to make the required premium  
4 payments.

5 (h) No carrier or agent or broker shall, directly or indirectly,  
6 engage in the following activities:

7 (1) Encourage or direct small employers to refrain from filing  
8 an application for coverage with a carrier because of the health  
9 status, claims experience, industry, occupation, or geographic  
10 location within the carrier's approved service area of the small  
11 employer or the small employer's employees.

12 (2) Encourage or direct small employers to seek coverage from  
13 another carrier because of the health status, claims experience,  
14 industry, occupation, or geographic location within the carrier's  
15 approved service area of the small employer or the small  
16 employer's employees.

17 (3) Employ marketing practices or benefit designs that will have  
18 the effect of discouraging the enrollment of individuals with  
19 significant health needs or discriminate based on the individual's  
20 race, color, national origin, present or predicted disability, age,  
21 sex, gender identity, sexual orientation, expected length of life,  
22 degree of medical dependency, quality of life, or other health  
23 conditions.

24 This subdivision shall be enforced in the same manner as Section  
25 790.03, including through Sections 790.035 and 790.05.

26 (i) No carrier shall, directly or indirectly, enter into any contract,  
27 agreement, or arrangement with an agent or broker that provides  
28 for or results in the compensation paid to an agent or broker for a  
29 health benefit plan to be varied because of the health status, claims  
30 experience, industry, occupation, or geographic location of the  
31 small employer or the small employer's employees. This  
32 subdivision shall not apply with respect to a compensation  
33 arrangement that provides compensation to an agent or broker on  
34 the basis of percentage of premium, provided that the percentage  
35 shall not vary because of the health status, claims experience,  
36 industry, occupation, or geographic area of the small employer.

37 (j) (1) A health benefit plan offered to a small employer, as  
38 defined in Section 1304(b) of PPACA and in Section 10753, shall  
39 not establish rules for eligibility, including continued eligibility,  
40 of an individual, or dependent of an individual, to enroll under the

1 terms of the plan based on any of the following health status-related  
2 factors:

- 3 (A) Health status.
- 4 (B) Medical condition, including physical and mental illnesses.
- 5 (C) Claims experience.
- 6 (D) Receipt of health care.
- 7 (E) Medical history.
- 8 (F) Genetic information.
- 9 (G) Evidence of insurability, including conditions arising out  
10 of acts of domestic violence.
- 11 (H) Disability.
- 12 (I) Any other health status-related factor as determined by any  
13 federal regulations, rules, or guidance issued pursuant to Section  
14 2705 of the federal Public Health Service Act.

15 (2) Notwithstanding Section 10291.5, a carrier shall not require  
16 an eligible employee or dependent to fill out a health assessment  
17 or medical questionnaire prior to enrollment under a health benefit  
18 plan. A carrier shall not acquire or request information that relates  
19 to a health status-related factor from the applicant or his or her  
20 dependent or any other source prior to enrollment of the individual.

21 (k) (1) A carrier shall consider as a single risk pool for rating  
22 purposes in the small employer market the claims experience of  
23 all insureds in all nongrandfathered small employer health benefit  
24 plans offered by the carrier in this state, whether offered as health  
25 care service plan contracts or health insurance policies, including  
26 those insureds and enrollees who enroll in coverage through the  
27 Exchange and insureds and enrollees covered by the carrier outside  
28 of the Exchange.

29 (2) At least each calendar year, and no more frequently than  
30 each calendar quarter, a carrier shall establish an index rate for the  
31 small employer market in the state based on the total combined  
32 claims costs for providing essential health benefits, as defined  
33 pursuant to Section 1302 of PPACA and Section 10112.27, within  
34 the single risk pool required under paragraph (1). The index rate  
35 shall be adjusted on a marketwide basis based on the total expected  
36 marketwide payments and charges under the risk adjustment and  
37 reinsurance programs established for the state pursuant to Sections  
38 1343 and 1341 of PPACA *and Exchange user fees, as described*  
39 *in subdivision (d) of Section 156.80 of Title 45 of the Code of*  
40 *Federal Regulations*. The premium rate for all of the carrier's

1 nongrandfathered health benefit plans shall use the applicable  
2 index rate, as adjusted for total expected marketwide payments  
3 and charges under the risk adjustment and reinsurance programs  
4 established for the state pursuant to Sections 1343 and 1341 of  
5 PPACA, subject only to the adjustments permitted under paragraph  
6 (3).

7 (3) A carrier may vary premium rates for a particular  
8 nongrandfathered health benefit plan from its index rate based  
9 only on the following actuarially justified plan-specific factors:

10 (A) The actuarial value and cost-sharing design of the health  
11 benefit plan.

12 (B) The health benefit plan's provider network, delivery system  
13 characteristics, and utilization management practices.

14 (C) The benefits provided under the health benefit plan that are  
15 in addition to the essential health benefits, as defined pursuant to  
16 Section 1302 of PPACA. These additional benefits shall be pooled  
17 with similar benefits within the single risk pool required under  
18 paragraph (1) and the claims experience from those benefits shall  
19 be utilized to determine rate variations for health benefit plans that  
20 offer those benefits in addition to essential health benefits.

21 (D) Administrative costs, excluding any user fees required by  
22 the Exchange.

23 (E) With respect to catastrophic plans, as described in subsection  
24 (e) of Section 1302 of PPACA, the expected impact of the specific  
25 eligibility categories for those plans.

26 (I) If a carrier enters into a contract, agreement, or other  
27 arrangement with a third-party administrator or other entity to  
28 provide administrative, marketing, or other services related to the  
29 offering of health benefit plans to small employers in this state,  
30 the third-party administrator shall be subject to this chapter.

31 (m) (1) Except as provided in paragraph (2), this section shall  
32 become inoperative if Section 2702 of the federal Public Health  
33 Service Act (42 U.S.C. Sec. 300gg-1), as added by Section 1201  
34 of PPACA, is repealed, in which case, 12 months after the repeal,  
35 carriers subject to this section shall instead be governed by Section  
36 10705 to the extent permitted by federal law, and all references in  
37 this chapter to this section shall instead refer to Section 10705,  
38 except for purposes of paragraph (2).

1 (2) Paragraph (3) of subdivision (b) of this section shall remain  
2 operative as it relates to health benefit plans offered through the  
3 Exchange.

4 SEC. 4. Section 10965.3 of the Insurance Code is amended to  
5 read:

6 10965.3. (a) (1) On and after October 1, 2013, a health insurer  
7 shall fairly and affirmatively offer, market, and sell all of the  
8 insurer's health benefit plans that are sold in the individual market  
9 for policy years on or after January 1, 2014, to all individuals and  
10 dependents in each service area in which the insurer provides or  
11 arranges for the provision of health care services. A health insurer  
12 shall limit enrollment in individual health benefit plans to open  
13 enrollment periods and special enrollment periods as provided in  
14 subdivisions (c) and (d).

15 (2) A health insurer shall allow the policyholder of an individual  
16 health benefit plan to add a dependent to the policyholder's health  
17 benefit plan at the option of the policyholder, consistent with the  
18 open enrollment, annual enrollment, and special enrollment period  
19 requirements in this section.

20 (b) An individual health benefit plan issued, amended, or  
21 renewed on or after January 1, 2014, shall not impose any  
22 preexisting condition provision upon any individual.

23 (c) (1) A health insurer shall provide an initial open enrollment  
24 period from October 1, 2013, to March 31, 2014, inclusive, and  
25 annual enrollment periods for plan years on or after January 1,  
26 2015, from October 15 to December 7, inclusive, of the preceding  
27 calendar year.

28 (2) Pursuant to Section 147.104(b)(2) of Title 45 of the Code  
29 of Federal Regulations, for individuals enrolled in noncalendar-year  
30 individual health plan contracts, a plan shall provide a limited open  
31 enrollment period beginning on the date that is 30 calendar days  
32 prior to the date the policy year ends in 2014.

33 (d) (1) Subject to paragraph (2), commencing January 1, 2014,  
34 a health insurer shall allow an individual to enroll in or change  
35 individual health benefit plans as a result of the following triggering  
36 events:

37 (A) He or she or his or her dependent loses minimum essential  
38 coverage. For purposes of this paragraph, both of the following  
39 definitions shall apply:

1 (i) “Minimum essential coverage” has the same meaning as that  
2 term is defined in subsection (f) of Section 5000A of the Internal  
3 Revenue Code (26 U.S.C. Sec. 5000A).

4 (ii) “Loss of minimum essential coverage” includes, but is not  
5 limited to, loss of that coverage due to the circumstances described  
6 in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the  
7 Code of Federal Regulations and the circumstances described in  
8 Section 1163 of Title 29 of the United States Code. “Loss of  
9 minimum essential coverage” also includes loss of that coverage  
10 for a reason that is not due to the fault of the individual.

11 (iii) “Loss of minimum essential coverage” does not include  
12 loss of that coverage due to the individual’s failure to pay  
13 premiums on a timely basis or situations allowing for a rescission,  
14 subject to clause (ii) and Sections 10119.2 and 10384.17.

15 (B) He or she gains a dependent or becomes a dependent.

16 (C) He or she is mandated to be covered as a dependent pursuant  
17 to a valid state or federal court order.

18 (D) He or she has been released from incarceration.

19 (E) His or her health coverage issuer substantially violated a  
20 material provision of the health coverage contract.

21 (F) He or she gains access to new health benefit plans as a result  
22 of a permanent move.

23 (G) He or she was receiving services from a contracting provider  
24 under another health benefit plan, as defined in Section 10965 or  
25 Section 1399.845 of the Health and Safety Code for one of the  
26 conditions described in subdivision (a) of Section 10133.56 and  
27 that provider is no longer participating in the health benefit plan.

28 (H) He or she demonstrates to the Exchange, with respect to  
29 health benefit plans offered through the Exchange, or to the  
30 department, with respect to health benefit plans offered outside  
31 the Exchange, that he or she did not enroll in a health benefit plan  
32 during the immediately preceding enrollment period available to  
33 the individual because he or she was misinformed that he or she  
34 was covered under minimum essential coverage.

35 (I) He or she is a member of the reserve forces of the United  
36 States military returning from active duty or a member of the  
37 California National Guard returning from active duty service under  
38 Title 32 of the United States Code.

39 (J) With respect to individual health benefit plans offered  
40 through the Exchange, in addition to the triggering events listed

1 in this paragraph, any other events listed in Section 155.420(d) of  
2 Title 45 of the Code of Federal Regulations.

3 (2) With respect to individual health benefit plans offered  
4 outside the Exchange, an individual shall have 60 days from the  
5 date of a triggering event identified in paragraph (1) to apply for  
6 coverage from a health care service plan subject to this section.

7 With respect to individual health benefit plans offered through the  
8 Exchange, an individual shall have 60 days from the date of a  
9 triggering event identified in paragraph (1) to select a plan offered  
10 through the Exchange, unless a longer period is provided in Part  
11 155 (commencing with Section 155.10) of Subchapter B of Subtitle  
12 A of Title 45 of the Code of Federal Regulations.

13 (e) With respect to individual health benefit plans offered  
14 through the Exchange, the effective date of coverage required  
15 pursuant to this section shall be consistent with the dates specified  
16 in Section 155.410 or 155.420 of Title 45 of the Code of Federal  
17 Regulations, as applicable. A dependent who is a registered  
18 domestic partner pursuant to Section 297 of the Family Code shall  
19 have the same effective date of coverage as a spouse.

20 (f) With respect to an individual health benefit plan offered  
21 outside the Exchange, the following provisions shall apply:

22 (1) After an individual submits a completed application form  
23 for a plan, the insurer shall, within 30 days, notify the individual  
24 of the individual's actual premium charges for that plan established  
25 in accordance with Section 10965.9. The individual shall have 30  
26 days in which to exercise the right to buy coverage at the quoted  
27 premium charges.

28 (2) With respect to an individual health benefit plan for which  
29 an individual applies during the initial open enrollment period  
30 described in subdivision (c), when the policyholder submits a  
31 premium payment, based on the quoted premium charges, and that  
32 payment is delivered or postmarked, whichever occurs earlier, by  
33 December 15, 2013, coverage under the individual health benefit  
34 plan shall become effective no later than January 1, 2014. When  
35 that payment is delivered or postmarked within the first 15 days  
36 of any subsequent month, coverage shall become effective no later  
37 than the first day of the following month. When that payment is  
38 delivered or postmarked between December 16, 2013, and  
39 December 31, 2013, inclusive, or after the 15th day of any  
40 subsequent month, coverage shall become effective no later than

1 the first day of the second month following delivery or postmark  
2 of the payment.

3 (3) With respect to an individual health benefit plan for which  
4 an individual applies during the annual open enrollment period  
5 described in subdivision (c), when the individual submits a  
6 premium payment, based on the quoted premium charges, and that  
7 payment is delivered or postmarked, whichever occurs later, by  
8 December 15, coverage shall become effective as of the following  
9 January 1. When that payment is delivered or postmarked within  
10 the first 15 days of any subsequent month, coverage shall become  
11 effective no later than the first day of the following month. When  
12 that payment is delivered or postmarked between December 16  
13 and December 31, inclusive, or after the 15th day of any subsequent  
14 month, coverage shall become effective no later than the first day  
15 of the second month following delivery or postmark of the  
16 payment.

17 (4) With respect to an individual health benefit plan for which  
18 an individual applies during a special enrollment period described  
19 in subdivision (d), the following provisions shall apply:

20 (A) When the individual submits a premium payment, based  
21 on the quoted premium charges, and that payment is delivered or  
22 postmarked, whichever occurs earlier, within the first 15 days of  
23 the month, coverage under the plan shall become effective no later  
24 than the first day of the following month. When the premium  
25 payment is neither delivered nor postmarked until after the 15th  
26 day of the month, coverage shall become effective no later than  
27 the first day of the second month following delivery or postmark  
28 of the payment.

29 (B) Notwithstanding subparagraph (A), in the case of a birth,  
30 adoption, or placement for adoption, the coverage shall be effective  
31 on the date of birth, adoption, or placement for adoption.

32 (C) Notwithstanding subparagraph (A), in the case of marriage  
33 or becoming a registered domestic partner or in the case where a  
34 qualified individual loses minimum essential coverage, the  
35 coverage effective date shall be the first day of the month following  
36 the date the insurer receives the request for special enrollment.

37 (g) (1) A health insurer shall not establish rules for eligibility,  
38 including continued eligibility, of any individual to enroll under  
39 the terms of an individual health benefit plan based on any of the  
40 following factors:

- 1 (A) Health status.
- 2 (B) Medical condition, including physical and mental illnesses.
- 3 (C) Claims experience.
- 4 (D) Receipt of health care.
- 5 (E) Medical history.
- 6 (F) Genetic information.
- 7 (G) Evidence of insurability, including conditions arising out
- 8 of acts of domestic violence.
- 9 (H) Disability.

10 (I) Any other health status-related factor as determined by any  
11 federal regulations, rules, or guidance issued pursuant to Section  
12 2705 of the federal Public Health Service Act.

13 (2) Notwithstanding subdivision (c) of Section 10291.5, a health  
14 insurer shall not require an individual applicant or his or her  
15 dependent to fill out a health assessment or medical questionnaire  
16 prior to enrollment under an individual health benefit plan. A health  
17 insurer shall not acquire or request information that relates to a  
18 health status-related factor from the applicant or his or her  
19 dependent or any other source prior to enrollment of the individual.

20 (h) (1) A health insurer shall consider as a single risk pool for  
21 rating purposes in the individual market the claims experience of  
22 all insureds and enrollees in all nongrandfathered individual health  
23 benefit plans offered by that insurer in this state, whether offered  
24 as health care service plan contracts or individual health insurance  
25 policies, including those insureds who enroll in individual coverage  
26 through the Exchange and insureds who enroll in individual  
27 coverage outside the Exchange. Student health insurance coverage,  
28 as such coverage is defined at Section 147.145(a) of Title 45 of  
29 the Code of Federal Regulations, shall not be included in a health  
30 insurer's single risk pool for individual coverage.

31 (2) Each calendar year, a health insurer shall establish an index  
32 rate for the individual market in the state based on the total  
33 combined claims costs for providing essential health benefits, as  
34 defined pursuant to Section 1302 of PPACA, within the single risk  
35 pool required under paragraph (1). The index rate shall be adjusted  
36 on a marketwide basis based on the total expected marketwide  
37 payments and charges under the risk adjustment and reinsurance  
38 programs established for the state pursuant to Sections 1343 and  
39 1341 of PPACA *and Exchange user fees, as described in*  
40 *subdivision (d) of Section 156.80 of Title 45 of the Code of Federal*

1 *Regulations.* The premium rate for all of the health insurer's health  
2 benefit plans in the individual market shall use the applicable index  
3 rate, as adjusted for total expected marketwide payments and  
4 charges under the risk adjustment and reinsurance programs  
5 established for the state pursuant to Sections 1343 and 1341 of  
6 PPACA, subject only to the adjustments permitted under paragraph  
7 (3).

8 (3) A health insurer may vary premium rates for a particular  
9 health benefit plan from its index rate based only on the following  
10 actuarially justified plan-specific factors:

11 (A) The actuarial value and cost-sharing design of the health  
12 benefit plan.

13 (B) The health benefit plan's provider network, delivery system  
14 characteristics, and utilization management practices.

15 (C) The benefits provided under the health benefit plan that are  
16 in addition to the essential health benefits, as defined pursuant to  
17 Section 1302 of PPACA and Section 10112.27. These additional  
18 benefits shall be pooled with similar benefits within the single risk  
19 pool required under paragraph (1) and the claims experience from  
20 those benefits shall be utilized to determine rate variations for  
21 plans that offer those benefits in addition to essential health  
22 benefits.

23 (D) With respect to catastrophic plans, as described in subsection  
24 (e) of Section 1302 of PPACA, the expected impact of the specific  
25 eligibility categories for those plans.

26 (E) Administrative costs, excluding any user fees required by  
27 the Exchange.

28 (i) This section shall only apply with respect to individual health  
29 benefit plans for policy years on or after January 1, 2014.

30 (j) This section shall not apply to an individual health benefit  
31 plan that is a grandfathered health plan.

32 (k) If Section 5000A of the Internal Revenue Code, as added  
33 by Section 1501 of PPACA, is repealed or amended to no longer  
34 apply to the individual market, as defined in Section 2791 of the  
35 federal Public Health Service Act (42 U.S.C. Sec. 300gg-4),  
36 subdivisions (a), (b), and (g) shall become inoperative 12 months  
37 after the date of that repeal or amendment and individual health  
38 care benefit plans shall thereafter be subject to Sections 10901.2,  
39 10951, and 10953.

1     SEC. 5. No reimbursement is required by this act pursuant to  
2     Section 6 of Article XIII B of the California Constitution because  
3     the only costs that may be incurred by a local agency or school  
4     district will be incurred because this act creates a new crime or  
5     infraction, eliminates a crime or infraction, or changes the penalty  
6     for a crime or infraction, within the meaning of Section 17556 of  
7     the Government Code, or changes the definition of a crime within  
8     the meaning of Section 6 of Article XIII B of the California  
9     Constitution.

O